STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re:	)	**MPC 15-0203**	**MPC 110-0803**
	)	**MPC 208-1003**	**MPC 163-0803**
David S. Chase,	)	**MPC 148-0803**	**MPC 126-0803**
	)	**MPC 106-0803**	**MPC 209-1003**
Respondent.	)	**MPC 140-0803**	**MPC 89-0703**
	)	**MPC 122-0803**	**MPC 90-0703**
	)		**MPC 87-0703**

RESPONDENT'S MOTION FOR JUDGMENT AS A MATTER OF LAW

Respondent David S. Chase, M.D., hereby requests the Board to grant him judgment as a matter of law on the State's Superceding Specification of Charges.

I. Introduction.

The State has failed to meet its high burden of proving its allegations against Dr. Chase. As an initial matter, the State has not demonstrated that any of the 11 complaining patients was improperly recommended cataract surgery by Dr. Chase. With one exception, the State concedes that every patient had cataracts. Every patient admitted to complaining of visual symptoms. The State has introduced no testimony that the patients' symptoms were caused by something other than their cataracts. Although many of those patients chose not to have surgery, Dr. Chase acted professionally when he provided each patient with the choice of surgery if ***they*** believed that their vision no longer met their needs. Three patients chose surgery after being explicitly and repeatedly advised that it was an elective procedure that they should undergo only if they were no longer satisfied with their vision. The remaining eight patients chose not to have surgery, demonstrating the effectiveness of Dr. Chase's informed consent process. While the State's ophthalmologists may not have recommended surgery to these patients, Dr. Chase's surgical recommendations and treatment conformed exactly to the applicable standard of care.

Nor has the State proven that Dr. Chase falsified his charts in order to justify cataract surgeries. To the contrary, the State's own evidence shows that every patient complaint, test score, and cataract description was properly founded in the results of Dr. Chase's comprehensive evaluation and assessment of his patients and accurately reflected their functional visual deficits. Because the State has utterly failed to prove its allegations of falsification, the Board should grant judgment in favor of Dr. Chase as a matter of law on these claims as well.

Viewed as a whole, the State's own evidence has shown that Dr. Chase was an incredibly skilled and comprehensive physician. He incorporated new diagnostic and surgical techniques long before his peers. He conducted more vision testing and patient education than any other doctor who testified. He respected his patients enough to allow them to participate in important decisions regarding their eye care. The State has utterly failed to demonstrate that these practices were unprofessional.

The State's evidence has not simply fallen short. It has also demonstrated that the State itself has acted unprofessionally in prosecuting this case. The testimony of the State's own witnesses has proven that the Board's investigator, its expert witness Dr. Morhun, and the attorney representing the State have perpetrated a fraud upon the Board—intentionally concealing evidence that Dr. Chase's summary suspension was premised upon incomplete medical records, a purposefully falsified patient history, and admittedly incorrect expert conclusions. Dr. Morhun has now admitted that his expert opinion, upon which the summary suspension was based, was infected by all of these deficiencies. He went so far to admit that Dr. Chase did not receive a "fair shake" in the summary suspension proceeding that touched off this enforcement action.

Dr. Morhun's testimony also revealed that the Assistant Attorney General prosecuting this case has known of the fundamental errors in Dr. Morhun's opinion, and in this Board's

summary suspension decision, for over two years. It was wrong for the State to conceal from the Board the defective foundation of its case. Now that those defects have come to light, it would be equally wrong for this Board to look the other way. It should dismiss the Superceding Specification of Charges as a partial remedy for the State's patent misconduct.

II. Discussion.

A. The State Has Charged Dr. Chase With Recommending And Performing Unnecessary Cataract Surgery And Falsifying His Charts To Support His Surgical Decisions.

The State has charged Dr. Chase with violating the standards of professional conduct with respect to 11 patients. As to each patient, the crux of the State's allegations is that Dr. Chase improperly recommended or performed cataract surgery. The State does not claim that Dr. Chase mistakenly misdiagnosed his patients, or that he had an honest disagreement with his colleagues. Rather it has charged him with recommending and performing cataract surgery that he ***knew*** his patients did not need. It also contends that Dr. Chase's surgery recommendations constituted "willful," "immoral," and "dishonest" conduct, in violation of 26 V.S.A. §§ 1354(a)(14) and 1398, because Dr. Chase was allegedly putting his own interests ahead of his patients' well-being.

The State has also charged Dr. Chase with falsifying his patients' charts in several different ways in order to support his surgery recommendations. As to five patients, the State alleges that Dr. Chase purposefully "falsified" his patients' vision test scores because those scores were "improperly based on the results of the CST with BAT" and "not on the Snellen Test," (*see, e.g.,* Amended Superceding Specification of Charges ¶ 50 (Salatino), 96 (Lang), 291 (McGowan), 323 (Touchette)), or that he "improperly measured [his patients'] visual acuity by using the CST with BAT." (*Id.* ¶ 207 (Corning).) The State does not simply allege that Dr. Chase's charted vision scores were confusing: It contends that the CST with BAT scores are

nothing short of "false." (*Id.* ¶ 96.) The State alleges that Dr. Chase's decision to record his patients' CST with BAT vision also constitutes "unfitness to practice medicine," and "unprofessional," "immoral," and "dishonest" conduct in violation o f 26 V.S.A. §§ 1354(a)8) and 1398.

As to eight of the 11 patients, the State alleges that Dr. Chase purposefully falsified his charts when he described their cataracts as "dense," even though other physicians described them as early cataracts. (*Id.* ¶¶ 51-52 (Salatino); 100-01 (Lang); 147-48 (Grigas); 200-01 (Corning); 288-89 (McGowan); 318-19 (Touchette); 345-46 (Augood); 382-83 (Kerr).) The State contends that this, too, constitutes "unprofessional," "immoral," and "dishonest" conduct in violation of 26 V.S.A. §§ 1354(a)8) and 1398.

With respect to 4 of the 11 patients, the State contends that Dr. Chase purposefully falsified their visual complaints in his records. (*Id.* ¶¶ 91-92 (Lang), 144 (Grigas), 321 (Touchette), and 380 (Kerr).) The State claims that yet four other patients' records contain false entries that the patients wanted their cataracts removed, when in fact they chose against having surgery. (*Id.* ¶¶ 204 (Corning); 321 (Touchette); 347 (Augood); 380 (Kerr).) Finally, the State asserts that Dr. Chase falsified his records when his technicians wrote "second opinion given" as part of their summary of Dr. Chase's own informed consent process. (*Id.* ¶ 6 (Nordstrom), 53 (Salatino), 104-05 (Lang); 145-46 (Grigas); 202-03 (Corning); 292-93 (McGowan); 324-25 (Touchette); 347-48 (Augood); 386-78 (Kerr).) The State alleges that this entry falsely indicates that Dr. Chase's patients "received a second opinion from another physician as to [his patients'] need for cataract surgery." (*Id.* ¶ 292, 324, 386.)

The State has not charged Dr. Chase with chart falsifications other than those outlined above. Nor has it charged that he improperly recorded his physical findings, patient complaints, or vision test scores in the wrong sections of his charts. Finally, the State has not charged Dr.

Chase with any unprofessional conduct arising out of his decision to inform his patients of his surgical qualifications. The State and the Board are bound by these limitations in the Amended Superceding Specification of Charges.

B. The State Has The Burden Of Proving Each Of Its Allegations By A Preponderance Of The Evidence, And The Board Should Enter Judgment In Favor Of Dr. Chase If The State Fails To Meet That Burden During Its Case-In-Chief.

Dr. Chase is presumed innocent of all of the charges of unprofessional conduct the State has leveled against him. He does not need to disprove them in order to prevail. Instead, the State bears the burden of proving each of its allegations by a preponderance of the evidence. *See Huddleston v. University of Vermont*, 168 Vt. 249, 252 (1998). In order to find that the State has met its burden, the Board must conclude that Dr. Chase more likely than not engaged in the "immoral," "dishonest," and "unprofessional" conduct alleged. Thus, "if the conflicting evidence of the parties is of equal weight, or if the evidence of the [physician] outweighs that of the [State], the evidence of the [State] does not preponderate," and the Board must find in favor of Dr. Chase. *In re Muzzy*, 141 Vt. 463, 473 (1982).

This Board has previously noted that the Vermont Rules of Civil Procedure provide guidance on dealing with procedural issues left unaddressed by the Vermont Administrative Procedures Act, which governs this proceeding. Vermont Rule of Civil Procedure 50 provides that, when the party bearing the burden of proof rests it case, the opposing party is entitled to judgment as a matter of law if "there is no legally sufficient evidentiary basis for a reasonable jury to find for that party." V.R.C.P. 50(a)(1). Applying this standard, Dr. Chase is entitled to judgment as a matter of law if, accepting the evidence the State has offered during its case-in-chief, the Board cannot reasonably conclude that the State has proved its allegations by the preponderance of the evidence. In deciding this motion, the Board may therefore take into

account only that evidence the State introduced before resting its case. It cannot take into account any of the State's allegations that are not supported by the evidence, and it cannot take into account any evidence elicited during the Respondent's case. As discussed below, the evidence offered by the State during its case-in-chief falls far short of meeting the burden of proof, and Dr. Chase is entitled to judgment as a matter of law.

C. According To The Government's Evidence, It Is Appropriate To Offer A Patient Cataract Surgery If A Cataract Is Compromising The Patient's Vision, Cataract Surgery Offers A Reasonable Likelihood Of Improving The Patient's Vision, And Glasses Will Not Solve The Patient's Vision Problems.

According to every one of the State's expert physician witnesses, the American Academy of Ophthalmology's Preferred Practice Pattern ("AAO PPP") contains the guidelines governing cataract diagnosis and treatment. The AAO PPP states that cataract surgery is appropriate when the patient's "visual function no longer meets the patient's needs and . . . cataract surgery offers a reasonably likelihood of improvement." (Ex. 503B, at 15 (2001).)[1] The AAO PPP also states that it is inappropriate for a doctor to offer cataract surgery to a patient if the doctor concludes that a new glasses prescription will adequately address the patient's visual problems, even if they are caused by a cataract. (*Id.*) Because the AAO PPP's standard for cataract surgery depends on the patients' subjective evaluation of their own visual problems, the State's physician witnesses also agree that only the patient can decide when her visual symptoms are bad enough that she is willing to undergo cataract surgery to remedy them (Cavin at 208-10; Cleary at 53; Watson at 160.) Those same State witnesses concur that a patient cannot decide whether her symptoms are sufficiently bad to justify surgery until the physician offers cataract surgery to her and explains

[1] Unless otherwise indicated, all Exhibit numbers refer to Respondent's exhibits admitted by stipulation of the parties during the State's case-in-chief. All citations to witness testimony refer to the sworn hearing testimony of the State's witnesses. At the time of this writing, the transcripts of Dr. Morhun's and Dr. Tabin's testimony are not yet available. As a result, the citations to their testimony do not reference page numbers.

all of the potential risks and benefits involved. (Cavin at 209-10; Watson at 170, 177; Cleary at 53.)

A physician cannot tell how a cataract will affect a patient's vision simply by viewing the cataract through the slit lamp. (Cavin at 177; Morhun.) Even early cataracts can cause significant visual symptoms, and those symptoms can justify surgery. (Cavin at 177, 181; Cleary at 50; Irwin at 41, 106; Morhun; Ex. 819, Beaver Dam Study.) A person does not need to wait until her cataracts prevent her from doing what she wants or needs to do before having surgery; instead, it is enough that the cataracts have made those tasks more difficult or "less comfortabl[e]." (Cavin at 211-12; Watson at 160; Morhun.) As a result, according to the State's own experts, it is appropriate for a physician to provide a patient with the choice of cataract surgery when: (1) the patient has cataracts; (2) the patient complains of symptoms that the doctor attributes to the cataracts; (3) glasses are unlikely to resolve the symptoms; and (4) cataract surgery offers a reasonable likelihood of improvement. (*See, e.g.*, Cavin at 209; Watson at 160-61; Morhun.)

D. Physicians Have A Number Of Legitimate Tools To Help Them Assess The Visual Significance Of A Patient's Cataracts.

The State's witnesses have identified a number of important tools that ophthalmologists have at their disposal in assessing the existence and significance of patients' cataracts. First, every physician, including Dr. Chase, testified that, prior to making any decision regarding cataract surgery, a physician must detect a cataract in his patient's eye(s) via a physical examination.

If a cataract is detected upon physical examination, the doctor must next assess whether that cataract is of visual significance to the patient. The ophthalmologist determines visual significance through both patient histories and vision testing. A physician can take patient

histories through patient interviews, patient questionnaires, or both. (Cavin at 201-02; Watson at 58; Cleary at 27; Irwin at 85.) The AAO PPP directly endorses the use of questionnaires as part of the history-taking process, noting that "the assessment of functional status is a pertinent part of the patient's history and can be obtained by means of an interview or questionnaire." (Ex. 503B at 13.) However obtained, the patient's subjective assessment of her functional visual status is a crucial component of cataract diagnosis, evaluation, and treatment.

Because patients do not always recognize or complain of visual loss due to cataracts, (Ex. 503B at 12), physicians also have at their disposal a number of different vision tests that help them assess the functional significance of their patients' cataracts. All of the physician witnesses, including Dr. Chase, evaluated their patients' best corrected high contrast Snellen visual acuity. Indeed, the undisputed evidence demonstrates that Dr. Chase's office measured his patients' best corrected Snellen vision three separate times during each examination: once through use of an autorefractor, once by the technician making manual refractive measurements prior to dilation; and once by Dr. Chase, who re-refracted each patient after dilation. (Chase 9/11 at 153.)

While Snellen vision is important, it is often not helpful in detecting or assessing many of the real life visual symptoms caused by cataracts, including glare and loss of contrast sensitivity. (Ex. 503B at 14; Cavin at 193, 197; Watson 162, 167-68.) The AAO PPP states that it is appropriate for a doctor to perform contrast sensitivity and glare testing in order to overcome the shortcomings of Snellen vision testing: "Contrast sensitivity function and glare disability may be tested to measure vision loss and visual disability due to glare and loss of contrast sensitivity." (*Id.* at 14.) According to the PPP, glare testing can provide important additional information regarding patients' functional disability from cataract:

> Cataracts may cause severe visual disability in brightly lit situations such as ambient daylight or from oncoming auto headlights at night. Visual acuity in some patients with cataracts is normal or near normal when tested in a dark examination room, but when these patients are retested using a source of glare, visual acuity (or contrast sensitivity) drops precipitously.

(*Id.* at 14.) The State's doctor witnesses agreed, and admitted that patients with glare disability are more likely to have problems functioning in bright sunlight or while driving at night. (*See, e.g.,* Irwin at 127; Cleary at 30-31.)

The AAO PPP also states that contrast sensitivity testing is a more comprehensive way to detect loss of functional vision due to cataract:

> Contrast sensitivity testing measures the eye's ability to detect subtle variations in shading by using figures that vary in contrast, luminance, and spatial frequency. ***It is a more comprehensive measure of visual function than visual acuity, which determines perception of high-contrast letters and numbers [by use of Snellen testing].***

(Ex. 503B at 14 (emphasis added); Cleary at 35.) The State's doctors have all admitted that patients with decreased contrast sensitivity are more likely to have difficulty seeing in low light conditions, such as driving at night and reading in dim light. (Watson at 150-52; Cleary at 36-37; Irwin at 46.) The PPP confirms that cataract patients with contrast sensitivity deficits are much more likely to be involved in automobile accidents. (Ex. 503B at 10.)

Although the State's own evidence confirms that contrast sensitivity and glare testing are a more comprehensive and sensitive measure of many patients' decreased visual function due to cataracts, Dr. Chase is the only testifying doctor who performed CST and BAT on every one of the complaining patients. While Dr. Irwin and Dr. Morhun performed glare testing on three of the 11 patients (confirming significant glare disabilities in two, even using a high contrast chart and simulating lighting conditions on a partly cloudy day), no other doctor performed glare or CST to help assess the significance of the patients' cataracts or their visual complaints.

E. Although Other Physicians Did Not Offer The Complaining Patients Cataract Surgery, The State's Own Evidence Shows That Dr. Chase Acted Appropriately In Doing So.

The State has offered the testimony of seven physician witnesses, all of whom stated that they did not believe that the 11 complaining patients needed cataract surgery. However, the fact that these second-opinion doctors did recommended surgery does not mean that Dr. Chase acted unprofessionally in doing so. According to the State's own experts, competent and honest physicians can disagree as to when cataract surgery is appropriate for a particular patient. (Watson at 79; Morhun; Tabin.) In order to determine whether the State has met its burden of proving by a preponderance of the evidence that Dr. Chase acted unprofessionally in offering and/or performing cataract surgery, the Board must compare Dr. Chase's recommendations to the AAO PPP standard, articulated above, rather than to the recommendations of the State's experts. That comparison shows that Dr. Chase acted appropriately in offering cataract surgery to every one of the 11 patients. First, every patient had cataracts. Second, every patient had visual complaints associated with those cataracts. Third, glasses or other visual aids would not address the patients' symptoms. Finally, all of the patients were provided an informed consent process that made clear the elective nature of the recommended surgery and confirmed that surgery was appropriate only if their vision no longer met their needs. As a result, Dr. Chase's surgery recommendations were proper, whether or not the patients chose to go forward with the elective surgery.

1. With A Single Exception, The State Concedes That The Complaining Patients Had Cataracts.

With the exception of Ms. Nordstrom, who is discussed separately below, all of the complaining patients had cataracts according to the State's own doctors. Although some of the physician witnesses testified that the patients' cataracts were not advanced, or labeled them

nuclear scleroses rather than cataracts, each physician testified that the 10 patients had a cataract, defined to mean a "degradation in the optical quality of the crystalline lens through loss of clarity or change in color." (AAO PPP at 3; Cavin at 240, 250; Guilfoy at 248; Watson at 188; Cleary at 84; Irwin at 170, 191, 221-22; Tabin; Morhun.)

2. All Of The Patients Were Experiencing Visual Symptoms When They Saw Dr. Chase.

To a person, each of the 11 patients admitted that he or she was experiencing visual symptoms at the time of Dr. Chase's surgery recommendations. In some instances, the patients' complaints were recorded by Dr. Chase's technician at the outset of the examination. (See Ex. 501.) In others, the patients themselves recorded their symptoms on patient questionnaires. (*Id.*) In still others, Dr. Chase recorded additional patient symptoms after examining and speaking with the patients. Moreover, in each case, the patients ***admitted under oath*** that they were suffering visual symptoms at the time they saw Dr. Chase.

Helena Nordstrom complained of blurry vision and difficulty driving at night, among other things. (Nordstrom at 46; Ex. 501-HN-1-1, 4.) Frank Cole admitted that the told Dr. Chase's technician that he was having trouble driving at night. (Cole at 122; Ex. 501-FC-1-11.) Susan Lang told Dr. Chase that she was having trouble seeing instruments at work and was bothered by bright lights, among other things. (Lang at 61-63; Ex. 501-SL1-1-18, 24-25.) Dr. Olson was having trouble with his vision, was bothered by glare at night, and had retired in part due to declining vision. (Olson at 110-11; 119; Ex. 501-DO-1-1, 10.) Mr. Touchette was having difficulty reading the computer screen, trouble with intermediate and near vision, and "had to work to see things clearly." (Touchette at 159-60; Ex. 501-JT-1-8.)

Jan Kerr reported decreased visual acuity, both at distance and at near, along with difficulty driving at night and seeing in the dim light of the operating room where she worked.

(Kerr at 27-29; Ex. 501-JK-1-1, 8.) Margaret McGowan told Dr. Chase that she saw "starbursts" around lights when driving at night and "had trouble seeing with cars coming at [her] at night." (McGowan at 128-29; Ex. 501-MM-1-17, 27, 40.) Jane Corning reported that she was bothered by glare. (Corning at 240-41; Ex. 501-JC-1-4, 7.) Bill Augood said that he was having trouble with glare on bright days. (Augood at 60, 62; Ex. 501-WA-1-1,7.) Judith Salatino made a host of visual complaints, including but not limited to problems seeing traffic signs and steps and being bothered by glare, hazy vision, and dim light. (Salatino at 42-43; Ex. 501-JS-1-13, 19, 47.) Finally, Ms. Grigas told Dr. Chase that she as having more difficulty driving at night. (Grigas at 168; Ex. 501-MG-1-21, 35.) These complaints, described by the patients under oath and also documented in their medical records, amply demonstrate that the patients were symptomatic.

3. In Each Case, The Nature And Extent Of The Patients' Visual Symptoms Were Confirmed By Dr. Chase's CST And BAT.

Dr. Chase performed CST and BAT on all of the 11 patients. Upon testing, each patient exhibited a serious contrast sensitivity deficit as compared to the age-adjusted norms set by the manufacturer of Dr. Chase's VectorVision testing unit and recording slips. (Exs. 501-WA-1-9; 501-FC-1-28; 501-JC-1-17; 501-MG-1-47; 501-SL1-1-69; 501-MM-1-73; 501-HN-1-13; 501-DO-1-4; 501-JS-1-64; 501-JT-1-18; 501-JK-1-69.) Indeed, most of the patients' contrast sensitivity scores were far, far below normal. As noted above, the State's own physicians testified that reduced contrast sensitivity is a common cataract symptom and causes significant real-life visual disabilities, such as trouble seeing in poor or dim light, trouble driving at night, and difficulty seeing in other bright conditions, such as bright sunshine, oncoming headlights, and streetlights – the very symptoms of which these patients complained.

Although the State has repeatedly attempted to call into question the validity and usefulness of Dr. Chase's CST and BAT, it has introduced no actual evidence supporting a

conclusion that Dr. Chase's test results are anything but valid, accurate, and indicative of real and significant contrast sensitivity and glare problems in the 11 patients. Nor can it, because none of the State's ophthalmologists bothered to perform CST on the patients, even though the State knew CST was central to this case. That failure speaks volumes.

4. The State Has Introduced No Evidence That The Patients' Symptoms, Or Their Low CST and BAT Results, Were Caused By Anything Other Than Their Cataracts Or Could Be Remedied With Glasses.

As noted above, according to the State's own evidence, the complaining patients had cataracts and visual symptoms. Dr. Chase testified that, as to all 11 patients, he ruled out other possible causes of their symptoms, including uncorrected refractive error – such as nearsightedness, farsightedness, and astigmatism – and attributed their visual problems to their cataracts. The State suggests that the patients' cataracts did not cause their problems. However, it again has not introduced any actual evidence that the complaining patients' visual symptoms were caused by something else. This omission is fatal to the State's allegations. Because Dr. Chase is presumed innocent, and because the State bears the burden of proof, it must demonstrate to the Board that Dr. Chase was wrong when he concluded, based on 35 years of experience diagnosing and treating eye disease and decades of following the same patients, that their symptoms were caused by their cataracts, rather than something that could be addressed through non-surgical intervention, such as new glasses. The simple fact is this: The State has introduced no testimony, expert or otherwise, that the complaining patients' symptoms were the result of uncorrected refractive error that could be addressed with new spectacles. (*See, e.g.,* Irwin at 222; Tabin; Morhun.)

Indeed, all of the available evidence shows that new glasses would not have alleviated the patients' symptoms. It is undisputed that all of Dr. Chase's CST and BAT was performed after the patients were refracted and had been given their best possible correction. (Chase, 9/11 at

140-41.) As a result, the significant contrast sensitivity and glare deficits exhibited by the complaining patients upon testing were the product of their best possible corrected vision and by definition could not be improved with glasses. Notably, none of the State's physician witnesses attempted to improve the patients' glare vision or contrast sensitivity with new glasses, and therefore cannot take issue with Dr. Chase's conclusions. The State's unsupported arguments aside, the Board has no evidentiary basis on which to conclude that the patients' symptoms, or the contrast sensitivity and glare deficits, would have been addressed through means other than surgery.

5. It Is The Patient, Rather Than The Doctor, That Should Decide Whether Cataract Symptoms Are Bad Enough To Justify Surgery.

Instead of ascribing the patients' symptoms to other causes, the State and its witnesses alleged, over and over again, that the 11 patients' cataracts and cataract-related symptoms were simply not sufficiently advanced to warrant an offer of cataract surgery. (*See, e.g.,* Irwin at 174.) Yet the State's own witnesses admitted that even early cataracts can cause significant symptoms. (Cavin at 177, 181; Cleary at 50; Irwin at 41, 106; Morhun; Ex. 819, Beaver Dam Study.) Thus, once it is determined that a patient has cataract-induced visual symptoms that cannot be fixed with glasses, it is the patient, not the doctor, that must decide if the symptoms are bad enough to justify the risks of surgery. (Cavin at 208-10; Cleary at 53; Watson at 160.) The same physicians testified that a patient cannot intelligently make that decision until the physician offers cataract surgery and explains the potential risks and expected benefits. (Cavin at 209-10; Watson at 170, 177; Cleary at 53.)

The State's ophthalmologists nonetheless decided not to offer the choice of cataract surgery to the complaining patients. These doctors were no doubt more conservative than Dr. Chase in determining when to recommend cataract surgery. (*See* Watson at 181.) There is

nothing wrong with such conservatism, at least to a point. However, the fact that Dr. Chase gave his patients the choice, along with his recommendation and the information that they needed to make an intelligent decision, is in no way unprofessional. Instead, it conforms precisely to the American Academy of Ophthalmology's Preferred Practice Pattern.

6. The Surgical Patients Affirmatively Decided That They Were No Longer Seeing Well Enough To Suit Their Needs And Chose Cataract Surgery After Learning All Of The Risks And Benefits.

Only three of the 11 complaining patients actually had surgery: Ms. Salatino, Ms. Lang, and Ms. McGowan. The material facts surrounding their surgeries are as clear as they are undisputed. Ms. Salatino, Ms. Lang, and Ms. McGowan all had cataracts and visual symptoms. They all received an extensive informed consent presentation, begun by Dr. Chase and completed by his nurses, during which they were advised that they should only have cataract surgery if the felt they could no longer function adequately because of their sight. They all testified that they understood that it was their choice to have surgery or not, based on their own visual needs and symptoms. Yet they all chose surgery nonetheless. No physician has opined that those surgeries were unnecessary.

Each patient participated in an extensive informed consent process before being scheduled for cataract surgery – a process made possible by the fact that Dr. Chase owned his own ambulatory surgical center and could therefore design his informed consent process to serve his patients' needs, rather than the needs of a hospital. After Dr. Chase summarized the risks and benefits of surgery to his patients, a registered nurse completed the informed consent presentation. Although there was no requirement that the counseling be performed by a trained nurse, Dr. Chase always hired RNs for the position. (Chase, 9/12 at 154-55, 32-33.) Dr. Chase considered the nurse's informed consent presentation as an integral part of his examination. (*Id.*) The counseling nurse spent between one and two hours with each patient, describing cataracts

and cataract surgery, reviewing the risks and benefits of surgery, and taking pre-operative measurements of the patients' eyes. (*Id.*) Other doctors' informed consent processes took between 5 and 15 minutes. (Cavin at 227; Irwin at 141.)

Dr. Chase's nurse provided patients with a four-page informed consent document and reviewed it with them. Among other things, the informed consent document told patients:

> Except for unusual problems, a cataract operation is indicated only when you feel you cannot function adequately due to poor sight produced by a cataract, which is a cloudy natural lens inside the eye. The natural lens within your own eye with a slight cataract, although not perfect, has some advantages over any man-made lens. You and Dr. Chase are the only ones who can determine if or when you should have cataract operation – based on your own visual needs and medical considerations, unless you have an unusual cataract that may need immediate surgery.
>
> . . . .
>
> ***This is usually an elective procedure, meaning you do not have to have this operation.***

(See, e.g., Ex. 501-JS-1-029 (emphasis added).) Dr. Chase's informed consent document is far more comprehensive than the generic forms used by all ophthalmologists who perform surgery at Fletcher Allen. (See Ex. 820.) Unlike every other doctor who testified, Dr. Chase did not require his patients to sign the informed consent form on the day they scheduled the surgery. (Chase 9/21 at 31-32; Irwin at 143.) Instead, he asked every patient to take the document home, review it, discuss it with family, and call with any follow-up questions. (Chase 9/21 at 31-32; Salatino at 58.) The patients were only required to sign the informed consent document on the day of surgery, after all of their questions were addressed. (Chase 9/21 at 31-32; Salatino at 58.)

Surgical patients were also provided with educational cataract pamphlets pre-printed by the American Academy of Ophthalmology, the largest and most mainstream organization of ophthalmologists. That pamphlet informed patients: "With few

exceptions, the presence of a cataract will not harm your eye . . . . Many people have cataracts but can still see well enough to do the things they enjoy. ***The decision is up to you.***" (Ex. 616 at 13 (emphasis added).)

All three surgical patients testified that the informed consent process provided them with the information they needed to make an intelligent decision regarding surgery. (Lang at 66, 68; McGowan at 154-58; Salatino at 58-63.) All testified that they understood the nature of their choice, and that they should decline surgery if they felt they were seeing well enough without it. (Lang at 66, 68; McGowan at 154-58; Salatino at 58-63.) Yet all three chose surgery nonetheless, and all had excellent surgical outcomes.

It is difficult to imagine a set of facts—all confirmed by State witnesses—that more powerfully demonstrate that Dr. Chase's surgical patients all had "vision that no longer [met] their needs and for which cataract surgery provid[ed] a reasonable likelihood of improvement," as required by the American Academy of Ophthalmology. Notably, not a single doctor has testified that Dr. Chase was wrong to operate on these patients; they disclaimed any opinion on that topic. On the basis of the State's own evidence, the Board must rule as a matter of law that Dr. Chase's decision to perform surgery on Ms. Salatino, Ms. Lang, and Ms. McGowan conformed to professional standards. The State has failed to prove otherwise.

7. Dr. Chase's Recommendations To His Non-Surgical Patients Also Conformed To The Highest Standards Of Professionalism.

The remaining eight patients chose not to have surgery, even though Dr. Chase recommended it as treatment for their cataract-related visual symptoms. Dr. Chase requested that all of these patients go through the same informed consent process described above. Some

did, and decided against surgery after learning all of the risks and benefits. Others decided against surgery before completing the informed consent process. The State has argued that because these patients declined Dr. Chase's recommendation of surgery, their visual problems were not sufficiently severe and he was therefore wrong to recommend it. The evidence presented by the State does not support its arguments.

Because cataract surgery is an elective procedure, the propriety of which depends in large part on the patients' own assessment of her symptoms, it is not uncommon for patients to decide after completing the informed consent process that the low risks of cataract surgery outweigh its expected benefits. (Cavin at 231; Morhun.) Thus, the fact that a patient ultimately decides against elective surgery does not render the physician's recommendation unprofessional. (Watson at 177-78; Cavin at 231; Morhun.) In fact, a patient cannot intelligently choose to have surgery, or not, until the ophthalmologist offers it and describes the risks and benefits. (Cavin at 209-10; Watson at170; Cleary at 53.) As discussed above, all of the patients had cataracts and cataract related symptoms that could not be remedied through glasses. Dr. Chase therefore properly recommended surgery to fix their problems, if they desired. The fact that 8 of the 11 complaining patients chose not to have surgery forcefully demonstrates that Dr. Chase's informed consent process provided his patients with a real choice and was not designed to coerce them into having surgery that they did not need or want.

F. The State Has Not Demonstrated That Dr. Chase Falsified His Patients Charts To Support His Surgery Recommendations.

The Amended Superceding Specification of Charges next alleges that Dr. Chase falsified his patients' charts in order to support his surgery recommendations. Again, it is important to note that the State does not simply contend that Dr. Chase kept his charts in an improper or

confusing manner. Instead, it alleges that he willfully and affirmatively falsified his charts in a number of different ways.

1. Dr. Chase Did Not Falsify His Patients' Vision Test Scores.

In its Specification of Charges, the State alleges that Dr. Chase purposefully "falsified" his patients' vision test scores because those scores were "improperly based on the results of the CST with BAT" and "not on the Snellen Test." (*See, e.g.,* Amended Superceding Specification of Charges ¶ 50, 96, 291, 323.) The State also contends that Dr. Chase "improperly measured [his patients'] visual acuity by using the CST with BAT." (*Id.* ¶ 207.) However, the State has not introduced a shred of evidence that Dr. Chase's charted vision scores were "false" or "falsified" because they were based on CST and BAT. Nor has it presented an iota of proof that it is "improper" to measure a patients' vision through use of CST and BAT in addition to Snellen testing. To the contrary, the State's evidence points to the opposite conclusion.

According to the State's own witnesses and the American Academy of Ophthalmology, CST and BAT are legitimate parts of a cataract evaluation. (Ex. 503B at 14; Cleary at 35; Morhun.) Glare and contrast sensitivity testing often reveal significant real-life, cataract-related visual deficits that are not detected by Snellen testing. (Cavin at 193, 197; Watson at 162, 167-68.) In this sense, these tests provide a more accurate and proper assessment of patients' functional vision, not a "false" or "improper" assessment. If the State's evidence demonstrates anything, it is that simply performing Snellen testing on cataract patients may provide an incomplete assessment of how they see in real life.

Moreover, the State has not alleged or proven that Dr. Chase's CST with BAT scores were rendered "false" or "improper" simply by virtue of their position in the chart. The State's evidence shows that every ophthalmologist has a unique way of keeping his or her charts. (Watson at 183-84; Cleary at 54-55.) And each physician who has testified placed his or her

vision scores at a unique location within those charts. Most doctors were hard pressed to interpret other physicians' charts. (Cavin at 232-34; Watson at 184.) The State's evidence shows that ophthalmologists should organize their charts, and their vision scores, in a way that allows them to provide their patients with the highest quality ophthalmic care. (Cavin at 232.)

There is no evidence that Dr. Chase did anything other than that: His undisputed testimony is that he placed his patients CST with BAT scores on the front page of his examination notes when he concluded that those scores best reflected his patients' real life functional vision. (See, e.g. Chase 9/11 at 183-85.) He also recorded each patient's best corrected Snellen visual acuity on the vision test slip and placed that slip prominently at the very front of the patient's chart, along with any Snellen vision obtained through use of the autorefractor. (*See* Ex. 501, original patient charts; Chase 9/11 at 180.) When other physicians needed to review his charts, he sent them a summary sheet clearly labeling his CST with BAT scores as such. (*See, e.g.,* 501-HN-1-17.) When asked, he even told insurance companies exactly how he was charting vision. (Ex. 523.) The State has introduced no evidence that these scores are false, or that Dr. Chase's charting practices were misleading or improper. Dr. Chase is therefore entitled to judgment on this central component of the State's case.

2. Dr. Chase Did Not Falsely Describe His Patients' Cataracts When He Labeled Them "Dense."

The Specification of Charges next contends that Dr. Chase affirmatively falsified some of his patients' charts when he described their cataracts as "dense." As the sole basis for this allegation, the State relies on the fact that other ophthalmologists described the same cataracts as "early" cataracts, "trace cataracts," or cataracts rated "1" or "2" on a scale of 1 to 4. It has ignored, and asked the Board to discredit, Dr. Chase's consistent explanation that he used the

word "dense" to denote cataracts that were functionally visually significant, rather than to describe their physical attributes.

Those State's ophthalmologists, however, confirmed that there is no single rating system that all doctors must follow. (Cavin at 176-77; Watson at 131; Cleary at 43.) They also freely admitted that all rating scales used to describe cataracts are highly "subjective," "nebulous," and "imprecise." (Cavin at 175; Irwin at 108.) A physician is free to use the rating system that best helps him provide quality care to his patients. (Cavin at 174-75; Cleary at 47.) For instance, Dr. Cleary invented her own category of cataract, called "haze," to give herself more information on how her patients' cataracts were affecting their vision. (Cleary at 47.)

Examination of the State's physicians' charts reveals just how subjectively and differently all doctors describe cataracts. When two of the State's doctors examined the same patient, they ***almost never*** agreed in their physical description or grade of the patient's cataracts. In some instances, the same doctors even described the same cataracts differently on two separate visits. The State's single retained expert, Dr. Morhun, failed to identify both nuclear and cortical cataracts noted by other doctors on visits preceding and following his own. (*Compare* Ex. 501-MM-1-3 to 501-MM-2-19 and 2-20.) Dr. Cleary failed to identify nuclear, cortical, and posterior subcapsular cataracts diagnosed in Frank Cole by Dr. Maguire, a retinal specialist who was not even examining him for purposes of evaluating those cataracts. (*Compare* 501-FC-2-4 to 501-FC-2-32.) Dr. Tabin repeatedly failed to see cortical cataracts that he had personally identified in a patient on prior visits. (*Compare* Ex. 501-SL1-2-4 to 501-SL1-2-11.)

The only thing that the Board can conclude from the State's evidence is that all clinicians' identifications and physical descriptions of cataracts are highly subjective and display wide inter-observer and intra-observer variations. That subjectivity applies not only to the grade

assigned to a cataract; it extends to whether a cataract exists or not. When asked when he considers a "trace opacity" to be a cataract, Dr. Irwin replied: "It depends on the day." (Irwin at 121.) In light of this, it is nonsensical to label one physician's grading system as "false" simply because it is different—even vastly different—from another's. To do so would be to conclude that every one of the State's own physician witnesses was falsifying his or her charts as well.

Perhaps understanding that it cannot prove the falsification alleged in the Specification, the State has attempted to argue (but has not formally alleged) that Dr. Chase was wrong to combine a functional descriptor such as "dense" with his physical description of the type and location of the cataract. However, the State has not introduced any evidence that combining functional and physical descriptors is even marginally improper, much less unprofessional conduct warranting license suspension. In fact, many the State's own physicians admit that they do the same thing, adjusting the grade or description they assign to a cataract in order to take account of how that cataract is affecting the patient's vision. (Cavin at 174; Watson at 129-30, 137, 175; Cleary at 37-41, 44.) Dr. Cavin testified that, like Dr. Chase, he uses the descriptor "dense" in part to "describe to [him]self what [he] expect[s] its impact on vision to be." (Cavin at 174.) Dr. Irwin, too, admits to using a "functional definition" when describing cataracts, accounting for how the cataract affects vision. (Irwin at 39.) If, as the evidence shows, many other good physicians similarly combine functional and physical descriptors in order to best treat their patients, the Board cannot reasonably conclude that Dr. Chase acted unprofessionally in doing so.

Finally, the State has failed to show that anyone would be confused or misled by Dr. Chase's use of the "dense" descriptor. The State's own witnesses convincingly demonstrate that there exist no rules, whether promulgated by insurance companies, regulatory authorities, or professional organizations, that require cataracts to reach a certain grade before surgery is

proper. (Cavin at 176-77.) In fact, there is no requirement that a doctor grade cataracts at all. Every doctor to address the issue has testified that he or she would never rely on another doctor's description of a cataract to guide his or her surgical decision—in part because such descriptors are so subjective. (Cavin at 176; Watson at 136; Cleary at 59; Morhun.) For all of these reasons, Dr. Chase is entitled to judgment on the State's allegations that he purposefully falsified his descriptions of his patients' cataracts.

3. Dr. Chase Did Not Falsify His Patients' Symptoms.

As to four patients—Susan Lang, Marylen Grigas, Joseph Touchette, and Jan Kerr—the State alleges that Dr. Chase falsified some of the visual symptoms recorded in their charts. Upon cross-examination, however, all of these patients admitted that they complained of the very problems Dr. Chase summarized in their charts—and often noted the same symptoms in their own handwriting on patient questionnaires. Although the State has suggested than a doctor and his staff have an obligation to record verbatim the patients' complaints of symptoms, rather than summarizing or paraphrasing them, the State's evidence has proven something entirely different: According to the State's doctor witnesses, it is perfectly acceptable and professional for an ophthalmologist and his technicians to paraphrase their patients' complaints and to record their own understanding of the patients symptoms based on everything revealed during the course of the examination by the patient, her vision testing, and the eye doctor's physical exam. (Cavin at 20-03; Irwin at 203; Tabin.) The evidence also shows that Dr. Chase accurately did just that.

a. Dr. Chase Accurately Recorded Susan Lang's Symptoms.

The State first charges that Dr. Chase falsified Susan Lang's symptoms when he wrote that she could not see to drive safely. (Superceding Specification ¶¶ 91-92.) Dr. Chase's conclusion is entirely consistent with Ms. Lang's own description of her symptoms, both at the

time she saw Dr. Chase and at the hearing. In filling out her own history sheet, Ms. Lang complained of being bothered by "glare" and "halos." (Ex. 501-SL-1-24.) At the hearing, she admitted that she had been experiencing those symptoms when driving at night and that Dr. Chase voiced concern about her ability to drive safely. (Lang at 60; 54-55.) Her CST and BAT scores confirmed that Ms. Lang had a severe contrast sensitivity deficit when tested under glare conditions designed to simulate night driving. (*Id.* at 501-SL-1-69.) The AAO PPP, which the State has stipulated into evidence, confirms that patients with significant contrast sensitivity deficits are far more likely to be involved in automobile accidents than those without. (Ex. 503B at 10.) While Ms. Lang may not believe that her vision had fallen to the point that she was unsafe to drive, it was more than reasonable for Dr. Chase to conclude, and tell her, that it had. Moreover, Ms. Lang subsequently confirmed that her vision was no longer meeting her needs when she chose to undergo elective cataract surgery after receiving an extensive informed consent presentation, both oral and written, by Dr. Chase and his nurse. (Ex. 501-SL1-1-47.) She testified that, after surgery, her glare symptoms were "eliminated." (Lang at 75-76.) On the basis of the State's own evidence, the Board cannot find that Dr. Chase falsified Ms. Lang's symptoms.

b. Dr. Chase Accurately Recorded Marylen Grigas' Symptoms.

The State next contends that Dr. Chase falsified Ms. Grigas' chart when he wrote that she could not see to drive safely due to glare from her cataracts. (Superceding Specification ¶ 144.) However, on the day of her exam, Ms. Grigas filled out a questionnaire in which she stated that she was choosing to have cataract surgery because she was "bothered by glare," was having "trouble seeing in poor or dim light" and "driving at night," and was "concerned about driving." (Ex. 501-MG-1-35.) During her sworn testimony, Ms. Grigas admitted that she had been experiencing increased discomfort when driving at night. (Grigas at 168.) It would defy

common sense and the weight of the evidence to rule in the State's favor in light of these admissions.

c. Dr. Chase Accurately Recorded Mr. Touchette's Symptoms.

The State does not take issue with the fact that Joseph Touchette had blurry vision when he visited Dr. Chase in 1998. However, in paragraph 321 of the Specification, the State charges Dr. Chase with falsifying Mr. Touchette's chart when he wrote that Mr. Touchette's blurry vision "interfered with his life." Mr. Touchette readily admitted that he was experiencing increasing problems reading his computer screen due to deteriorating near and intermediate vision. (Touchette at 159-60.) He testified that he used the computer nearly every day for work. (Touchette at 191.) He told Dr. Chase's staff that he "had to work to see things clearly." (*Id.*) The technician placed this complaint in quotation marks to indicate that it was a verbatim account of Mr. Touchette's symptoms. (Ex. 501-JT-1-008; Touchette at 159-60.) His contrast sensitivity, measured with his best possible correction, also showed a significant deficit. (Ex. 501-JT-1-18.) As noted above, the AAO PPP states that blurry vision more than once or twice a month "has a significant impact on functional status and well-being, particularly on problems with work or other daily activities." (Ex. 503B at 10.) Dr. Chase was therefore well within the bounds of professionalism in concluding and recording that Mr. Touchette's near-daily blurred view of the computer screen interfered with his life. The fact that Mr. Touchette ultimately decided that the interference was not sufficient to warrant surgery does not render Dr. Chase's comments unreasonable or false.

d. Dr. Chase Accurately Recorded Ms. Kerr's Symptoms.

Finally, the State contends that Dr. Chase falsified Ms. Kerr's symptoms when he wrote in her chart that she "can't see to drive safely" at night. (Superceding Specification ¶ 380.) Once again, Dr. Chase's rendition of the patient's symptoms is entirely consistent with all of the

evidence presented by the State. First, Ms. Kerr admitted that she told Dr. Chase's technician that she was having difficulty seeing to drive at night, as recorded by the tech in her chart. (Ex. 501-JK-1-1; Kerr at 27-29.) In filling out her Eye Health History Form, she stated that she was experiencing "decreased vision." (Ex. 501-JK-1-8.) Her CST results, which reflected her best corrected contrast sensitivity and glare vision, confirmed that she was experiencing significant problems in glare conditions. (Ex. 501-JK-1-10.) Even Dr. Irwin's subsequent examination of Ms. Kerr revealed that her high contrast Snellen vision dropped to 20/60 in her right eye when exposed to the BAT on its medium setting. (Ex. 501-JK-2-12.) At the hearing, Ms. Kerr also revealed that she had been the at-fault driver in a serious automobile accident that was caused by her inability to see a stoplight when looking into the sun—a classic glare problem. (Kerr at 25-26.) In short, Dr. Chase's description of Ms. Kerr's symptoms was entirely consistent with her own description to his technician, her real life experience, Dr. Chase's test results, and the test results of Dr. Irwin.

4. Dr. Chase Did Not Falsify His Charts When He Recorded That His Patients Wanted Their Cataracts Removed.

The Amended Superceding Specification of Charges alleges that Dr. Chase falsified his charts when he wrote that four patients—Jane Corning, Joseph Touchette, William Augood, and Jan Kerr—wanted their cataracts removed. All four patients ultimately decided against having surgery. As a result, the State asks the Board to find that Dr. Chase purposefully falsified these patients' charts. The State does not contend that Dr. Chase mistakenly, or even negligently, misinterpreted his patients' wishes. Rather, it alleges that he wrote that his patients wanted cataract surgery when he knew they did not. The State's evidence supports no such allegation.

Dr. Chase testified that after he delivered his initial informed consent presentation to patients with visually significant cataracts, he asked the patients to visit his nurse in order to

complete the informed consent process, submit to preoperative measurements, and schedule cataract surgery. (Chase 9/12 at 32-33.) If the patient indicated that they did not want to visit the nurse, Dr. Chase would have his staff schedule a follow-up exam in one or two years. (Chase 9/11 at 164.) If the patient indicated that he or she would go to see the nurse, Dr. Chase noted in the chart that the patient wanted his or her cataracts removed, accurately reflecting his understanding of his patients' desires at that time. (Chase 9/25 at 147.) He would then send them out of his examination lane and to the nurse's office to complete the informed consent process and schedule surgery.

Jane Corning and Jan Kerr went to see the nurse and opted to postpone surgery after receiving the entire informed consent presentation. (*See* Ex. 501-JK-1-002; 501-JC-1-003.) Neither patient told Dr. Chase that she did not want cataract surgery; instead, each went to the nurse's office as he suggested, leaving him with to conclude that they were, in fact, scheduling surgery. (Corning at 270-71; Kerr at 43.) For both Ms. Corning and Ms. Kerr, the nurse accurately recorded in the chart that the patient had decided to postpone a decision regarding surgery. (Ex. 501-JK-1-002; 501-JC-1-003.) As a result, when viewed as a whole as they must be, the patients' charts accurately reflect their wishes regarding surgery.

Joe Touchette and William Augood opted not to go see the nurse, and instead left Dr. Chase's examination lane and, instead of seeing the nurse, exited the office, never to return. (Touchette at 170; Augood at 95-96.) Neither patient informed Dr. Chase that he was not going to see the nurse, as instructed. (Touchette at 184; Augood at 95-96.) Dr. Chase should not and cannot be penalized because his patients quietly decided against surgery without telling him or his nurses. To find otherwise would require Dr. Chase to read his patients' minds.

More importantly, for these patients too, the charts viewed as a whole accurately reflect that the patients had decided against surgery. There are no additional entries suggesting that the

patient completed the informed consent process, undertook preoperative testing, or scheduled surgery. Mr. Touchette's chart accurately notes "patient decided against surgery." (Ex. 501-JT-1-9.) In short, for each of the four patients, Dr. Chase's charts accurately reflect Dr. Chase's understanding of his patients' desires and accurately record that the patients ultimately decided against surgery. The State's claims of purposeful fabrication are unsupported by the medical records or the patients' sworn testimony.

5. Dr. Chase's Did Not Falsify His Charts When Technicians Wrote That A "Second Opinion" Was Given To His Patients.

Finally, the State argues that Dr. Chase falsified his charts when his scribes placed the notation "second opinion given" as part of their recording of Dr. Chase's informed consent presentation. The Superceding Specification of Charges contends that this entry indicates that Dr. Chase's patients "received a second opinion from another physician as to [his patients'] need for cataract surgery." (Superceding Specification ¶ ¶ 292, 324, 386.) The State's charge is as unsupported as it is nonsensical.

As an initial matter, the State has introduced absolutely no evidence that Dr. Chase wrote, or asked his scribes to write, "second opinion given" in his charts. As Dr. Chase has explained, his technicians invented this shorthand phrase to record the fact that he had given a portion of his standard informed consent presentation. (Chase 9/25 at 122-23.) Dr. Chase then went on to explain that presentation a length, and it is nothing as sinister as the State has alleged: Dr. Chase told each patient to whom he was recommending cataract surgery that "if she went to any other medical eye doctor . . . and said she came for a second opinion because Dr. Chase said she needed cataract surgery, she would be told [that] if she saw well enough to suit her, its not going to damage her eyes ***not*** to have the surgery." (Chase 9/25 at 84.) As Dr. Chase explained, his hypothetical "second opinion" was one of several ways in which he and his office staff explained

to patients that: (1) cataract surgery was elective, not necessary, and they should only have it if their vision no longer suited their needs; and (2) a cataract was not a life threatening condition, such as a tumor, that needed to be fixed immediately. (*Id.*) Dr. Chase's scribes chose to record this with the phrase "second opinion given." While Dr. Chase never instructed his scribes to write down that the patient was given a second opinion, he never objected to their chosen shorthand notation because he believed it adequately captured what he was telling his patients: Any good doctor will likely tell a patient that cataract surgery is elective and depends on her own visual needs. Notably, the State has called none of Dr. Chase's former scribes or technicians to refute his rendition, despite ample opportunity to do so. For good reason: They would confirm Dr. Chase's truthful account.

The State appears to contend that others might be misled by this notation to believe that the patients received a true second opinion while being examined by Dr. Chase. The State's interpretation of this notation is nonsensical in the extreme. No doctor can provide his patients with his own second opinion during the course of his examination. There exists no patient, physician, or insurer who could reasonably conclude otherwise.

The State is exploiting the "second opinion" notation to invent wrongdoing where none exists. The Board should reject the State's offer to join its flight of fancy and enter judgment in favor of Dr. Chase on these allegations as well.

G. The State Has Not Proven By A Preponderance Of The Evidence That Ms. Nordstrom Did Not Have Cataracts.

The State alleges that, alone among the 11 complaining patients, Ms. Nordstrom had no cataracts. The State's evidence on this point does not meet its burden of proving its allegations by a preponderance.

Ms. Nordstrom came to Dr. Chase complaining of blurry distance vision for approximately three weeks and difficulty seeing clearly to drive at night, among other things. (Ex. 501-1-HN-1; Nordstrom at 46.) When she viewed the Snellen chart in Dr. Chase's office, she performed poorly, both as measured by the autorefractor, the technician, and by Dr. Chase himself. (Nordstrom at 50; Ex. 501-HN-1-12, 13.) Even Ms. Nordstrom testified that when her vision was tested prior to dilation, the Snellen chart was blurry. (Nordstrom at 50.) The measurements taken by Dr. Chase's technicians showed that there had been no change in her glasses prescription that would account for her symptoms. (Ex. 501-HN-1-1.)

Dr. Chase's January 2003 examination revealed that Ms. Nordstrom was suffering from cataracts, which were causing her vision problems. He found no other ocular condition that might account for her symptoms. (Ex. 501-HN-1-2.) However, prior to performing cataract surgery on Ms. Nordstrom, Dr. Chase ordered her to get 2-hour blood sugar and CBC test. (Ex. 501-HN-1-2; Ex. 705; Chase 9/12 at 153-54.) Her surgery was contingent upon the results. (*Id.*) Dr. Chase testified that he did this in order to determine if her cataracts were caused by fluctuating blood sugar levels, which can cause transitory cataracts that disappear as sugar levels stabilize. (*Id.*) As always, he was concerned about his patients' entire health, not just their eyes. The State's ophthalmologists agree that fluctuating blood sugar levels can cause transitory cataracts, sometimes referred to as water clefts. (Cavin at 164-65; Tabin; Morhun.) Dr. Morhun acknowledged that the only reason an ophthalmologist might order a patient to have a blood sugar test is concern that a patient's glucose intolerance is affecting her vision and to detect incipient diabetes, further bolstering Dr. Chase's explanation. (Morhun.) Ms Nordstrom declined to get the blood sugar test Dr. Chase had ordered and did not go forward with surgery. She testified that her distance vision nonetheless improved over the coming months—a fact that she attributed to new glasses.

Dr. Morhun found no cataract when he examined Ms. Nordstrom five months later in June 2003. By that time, her Snellen vision had greatly improved. Dr. Morhun confirmed, however, that her vision did not improve due to new glasses because her prescription had not changed. (Morhun.) Indeed, based on his examination, Dr. Morhun could not find any reason for Ms. Nordstrom's radically improved vision. Although the State bears the burden of proof, it has offered no explanation for Ms. Nordstrom's case.[2] This failure alone requires the Board to rule in favor of Dr. Chase' on the State's allegation that she had no cataracts.

However, the State's own evidence suggests two highly plausible explanations, both consistent with Dr. Chase's innocence. First, as discussed above, there is a strong possibility that Ms. Nordstrom did, in fact, have fluctuating blood sugar levels that caused transitory cataracts that interfered with her vision. Those cataracts had disappeared by the time Dr. Morhun examined her five months later.

Second, there is a strong possibility that Dr. Morhun simply failed to see Ms. Nordstrom's early cataracts, which were intermittently interfering with her vision. This explanation is consistent with Dr. Morhun's failure to see several other cataracts diagnosed by the State's other ophthalmologist witnesses: Dr. Tabin diagnosed Ms. McGowan as having a nuclear cataract, (Ex. 501-MM-2-20), but Dr. Morhun failed to see it, (Ex. 501-MM-2-3); Dr. Irwin diagnosed Ms. McGowan as having a cortical cataract, (Ex. 501-MM-2-19), but Dr. Morhun failed to see it, (Ex. 501-MM-2-3); Dr. Irwin diagnosed Ms. Salatino as having a cortical cataract, (Ex. 501-JS-2-011), but Dr. Morhun failed to see it. (Ex. 501-JS-2-11.) It is also consistent with the lack of care Dr. Morhun exercised when reviewing Dr. Chase's charts for the Board's investigator, when he overlooked that Dr. Chase had refracted Ms. Nordstrom,

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[2] Although Dr. Morhun speculated that Ms. Nordstrom's fluctuating vision could have an number of theoretical causes, he admitted that neither his examination nor Dr. Chase's examination offers support for those theories. (Morhun.) Ms. Nordstrom has refused to be re-examined by Dr. Chase or his experts.

overlooked that her glasses had not changed, and overlooked that he had been provided with incomplete records that were obviously missing the bottom one-quarter of each page. Dr. Morhun's failure to notice cataracts in Ms. Nordstrom's eyes is particularly unsurprising when viewed in light of the undisputed fact that Ms. Nordstrom falsified her symptoms to him, specifically disclaiming that she had ever experienced vision problems.

Due to the serious omissions and deficiencies attending Dr. Morhun's testimony, and the lack of any explanation of Ms. Nordstrom's symptoms by Dr. Morhun, the Board must find that State has failed to prove by a preponderance of the evidence that Ms. Nordstrom had no cataracts when examined by Dr. Chase. In light of the mistakes Dr. Morhun made, no reasonable Board could rely upon him to revoke a physician's license.

H. The Board Should Dismiss This Case Due To The State's Misconduct.

The conduct of the State, its expert, and the Board's investigator with respect to the investigation and prosecution of Ms. Nordstrom's complaint raises serious due process concerns that transcend the sufficiency of the State's evidence and require dismissal of the charges against Dr. Chase.

This case commenced with the complaint of Helena Nordstrom, which the State used to summarily suspend Dr. Chase's license and end his 35-year career. None of the other 10 complaining patients raised their concerns with the Board until after Dr. Chase's summary suspension was reported widely in the press. Each of those witnesses testified that they did not consider complaining to the Board until they read of Ms. Nordstrom's complaint in conjunction with the summary suspension. That summary suspension also fueled a federal criminal investigation and prosecution of Dr. Chase, which was begun when federal investigators read about the summary suspension in the Burlington Free Press. Since then, over 20 former patients have filed cataract-related malpractice cases against Dr. Chase; prior to the suspension, he had

never been sued regarding his cataract care. In short, this entire proceeding, the unsuccessful criminal case that preceded it, and the civil cases to follow, were premised on the Nordstrom summary suspension proceeding.

In support of its summary suspension motion, the State relied primarily upon the written report of Dr. Patrick Morhun, who concluded that Dr. Chase's treatment of Ms. Nordstrom had fallen below the standard of care in several different ways. Since then, however, Dr. Morhun has explicitly recanted many of the opinions on which the State and the Board relied in seeking and granting the summary suspension of Dr. Chase's license. He has testified that he is no longer confident in the remainder of his opinion, in which he stated that Ms. Nordstrom never had cataracts. For instance, in that opinion, Dr. Morhun stated that Dr. Chase never refracted Ms. Nordstrom in order to determine her best corrected visual acuity, a major breach of the standard of care. He now admits that Dr. Chase's chart shows no fewer than three separate refractions. In support of the summary suspension, Dr. Morhun also opined that Dr. Chase never attempted to give Ms. Nordstrom the new pair of glasses she claims to have requested. He now concedes that Dr. Chase's chart contains a new prescription. Most importantly, Dr. Morhun concluded that Ms. Nordstrom would have seen a "tremendous improvement" in her vision with a simple glasses change. He now admits that he was terribly wrong: there was no change in Ms. Nordstrom's glasses. Dr. Morhun was able to offer no explanation for these fundamental mistakes.

At the hearing, Dr. Morhun also revealed that the entirety of his opinion regarding Dr. Chase's treatment of Ms. Nordstrom was founded on materially incomplete medical records that were misrepresented as complete by Investigator Ciotti. For instance, Mr. Ciotti did not provide Dr. Morhun with the results of Ms. Nordstrom's autorefraction, which contained her clearly labeled Snellen visual acuity scores. The faxed records that Mr. Ciotti did give him were

missing the bottom one-quarter of each page, a fact Dr. Morhun did not notice until Dr. Chase's defense team pointed it out, fatally damaging Dr. Morhun's claim that he had conducted a "careful" review of Dr. Chase's records.

Dr. Morhun also testified that his opinion was based on Ms. Nordstrom's falsified patient history. He asked Ms. Nordstrom if she had experienced any visual symptoms in the past, and she answered "no." Of course, under oath, she admitted experiencing blurry vision just a few months earlier. Ms. Nordstrom denied any past symptoms at the direction of Mr. Ciotti, who instructed her not to tell Dr. Morhun anything about the reason for her visit. As a result, Dr. Morhun was unaware of Ms. Nordstrom's recent visual complaints – a key component of any cataract diagnosis.

Dr. Morhun admitted that both his examination of, and opinion regarding, Ms. Nordstrom's condition would have been different if she had not lied to him. His opinion also would have been different if he had received Dr. Chase's full medical record, or reviewed the incomplete medical record more carefully. Dr. Morhun would have explored the possibility that Ms. Nordstrom was experiencing fluctuating vision due to transient cataracts caused by unstable blood sugar levels. He would not have incorrectly opined that Dr. Chase failed to refract Ms. Nordstrom or that her vision could have been "tremendously improved" with new glasses. He stated that he would not have opined that Ms. Nordstrom never had cataracts, at least without first getting the results of her blood sugar test. In light of these fundamental errors in his opinion and the information on which it was based, Dr. Morhun has gone so far to admit that Dr. Chase did not get a "fair shake" at the summary suspension hearing.

Of perhaps the most concern was Dr. Morhun's testimony that the he, the Board's investigator, and the Assistant Attorney General responsible for prosecuting this case have known about these errors since at least July 2004, when Respondent's counsel deposed Dr.

Morhun in the presence of Mr. Winn. Although Dr. Morhun knew that Dr. Chase's license was suspended, and his career ended, on the basis of mistaken information, he did not come forward and admit his mistake to the Board. Although Phil Ciotti knew that Dr. Chase's license had been suspended, and his career ended, on the basis of incomplete and inaccurate medical records and patient information, he did not come forward and inform the Board. And although Attorney Winn knew that he had successfully ended a physician's 35-year career on the basis of a fundamentally mistaken expert opinion, he did not come forward and inform the Board, preferring instead to cover up his mistakes and those of his main expert while exploiting the resulting publicity.[3]

The actions of Dr. Morhun, Mr. Ciotti, and Mr. Winn were wrong. They learned that a doctor's career had been ruined on the basis of an incorrect and incomplete expert opinion, but sat silently by. After listening to Dr. Morhun's testimony, the Board now knows that its summary suspension order, which touched off this entire proceeding, was founded on incomplete, inaccurate, and arguably fraudulent information. It would be equally wrong for this Board to stand idly by in the face of such manifest injustice. The Board should end this proceeding, dismiss the State's charges, and investigate the State's activities before Dr. Chase is subjected to further deprivation of his due process rights.

There is ample caselaw supporting dismissal as an appropriate remedy for government misconduct, particularly when it involves the suppression or falsification of material evidence. *See, e.g., Government of the Virgin Islands v. Fahie*, 419 F.3d 249, 254-55 (3d Cir. 2005); *United States v. Osorio*, 929 F.2d 753, 760 (1st Cir. 1991); *United States v. Miranda*, 526 F.2d

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[3] Since the outset of this case, the State has attempted to preclude Dr. Chase from separately challenging the basis for the summary suspension, arguing that he should do so at the merits hearing. Once at the hearing, however, Mr. Winn objected to counsel's cross-examination of Dr. Morhun regarding his summary suspension opinion, arguing that it was not "relevant." The real reasons for the State's objection should by now be apparent to the Board.

1319, 1324 n.4 (2d Cir. 1975). As the Third Circuit stated in *Fahie*, dismissal is an appropriate remedy in cases of purposeful governmental misconduct "because those cases call for penalties which are not only corrective but highly deterrent." *Fahie*, 419 F.3d at 254-55. Indeed, presenting to the tribunal evidence that the government knows to be untrue is widely acknowledged as the single most serious form of misconduct. *See, e.g.*, *United States v. Udechukwu*, 11 F.3d 1101, 1106 (1st Cir. 1993) (government's affirmative actions to mislead tribunal found indefensible); *United States v. Valentine*, 820 F.2d 565, 570-71 (2d Cir. 1987) (government's arguments contrary to known evidence deprived defendant of fair trial); *United States v. Universita*, 298 F.2d 365, 267 (2d Cir. 1962) (observing that the "prosecution has a special duty not to mislead; *the government should, of course, never make affirmative statements contrary to what it knows to be the truth*" (emphasis added)).

These proscriptions on misleading a tribunal have particular currency when that tribunal is a volunteer board. Because its members are part-time volunteers, this Board relies heavily its Assistant Attorneys General to provide the accurate and complete information it needs to make good decisions. The profession and the public, too, rely on the State to deal fairly with them and the Board. This is especially true with respect to summary suspensions, where the Respondent is not allowed to cross-examine the State's evidence or to present his own. The State has utterly failed to meet its obligations to the Board, the Respondent, and the public, ruining Dr. Chase's career in the process. That failure cannot go unnoticed or unpunished. This case should be dismissed.

Dated at Burlington, Vermont, this 15th day of December, 2006.

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